Disclosure of Ownership and Control Interest Statement

Form Approved

Department of Health and Human Services

Health Care Financing Administration	OMB No.0938-0086
I. Identifying Information	
(a) Name of Entity:	D/B/A
Provider No.:	
Vendor No.:	
Street Address Line One:	
Street Address Line Two:	 _
City/County:	
State:	
Zip Code:	
Telephone No.:	Ext
(b) (To be completed by HCFA Regional Office)	
Chain Affiliate No.:	LB1
A. Are there any individuals or organizations has control interest of 5% or more in the institute been convicted of a criminal offense related organizations in any of the programs established [] Yes [] No LB2	naving a direct or indirect ownership or tion, organization, or agency that have I to the involvement of such persons, or
B. Are there any directors, officers, agents, or agency, or organization who have been con their involvement in such programs establis [] Yes [] No LB3	victed of a criminal offense related to
C. Are there any individuals currently employed organization in a managerial, accounting, at employed by the institution's, organization's carrier within the previous 12 months? (Title [] Yes [] No LB4	uditing, or similar capacity who were s, or agency's fiscal intermediary or
III. (a) List names, addresses for individuals, or the cindirect ownership or a controlling interest in the ci	2

indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks. LB5

Name	Address	EIN		
(b) Type of Entity: [] Sole Proprietorship [] Partnership [] Corporation LB6 [] Unincorporated Association [] Other (Specify)				
(c) If the disclosing entity i for corporations under Rem	s a corporation, list names, addresses of the Direct narks.	tors, and EINs		
(d) Are any owners of the facilities? (Example, sole p	each of the following questions. disclosing entity also owners of other Medicare/M roprietor, partnership or members of Board of Dir lividuals, and provider numbers. LB7			
Name	Address	Provider Number		
IV.				
 a) Has there been a change in ownership or control within the year? [] Yes [] No If yes, give date(yyyy) LB8 				
b) Do you anticipate at [] Yes []	ny change of of ownership or control within the ye	ear?		
c) Do you anticipate fi	ling for bankruptcy within the year?			
If yes, when?	(yyyy) LB10			
organization?	by a management company or leased in whole or p	part by another		
[] Yes [] If yes, give date of ch	No nange in operations: (yyyy) LI	B11		

VI. Has there been a change in Administrator, Director, or Nursing or Medical Director within the last Year?
[] Yes [] No LB12
VII. (a) Is this facility chain affiliated? (If yes, list name, address or Corporation and EIN.) [] Yes [] No Name:
EIN #: LB13
Address:LB14
(b) If the answer to Question VII a. is no, was the facility ever affiliated with a chain? If yes, list Name, Address of Corporation, and EIN.) [] Yes [] No LB18 Name: EIN #: Address: LB19
VIII. Have you increased your bed capacity by 10% or more than 10 beds, whichever is greater, within the last two years? [] Yes [] No LB15 If yes, give year of change:(yyyy)
Current no. beds: LB16
Prior no. beds:LB17
Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary as appropriate.
Authorized Representative Name:
Title:
Signature:
Date:/ (mm/dd/yy)
Remarks:

Mail this form to:

Health Care Facilities Division 825 North Capitol Street, NE 2nd floor Washington, DC 20002 (202) 442-5888